

CULTURAL SENSITIVITY AUDIT TOOL
FOR MENTAL HEALTH SERVICES

Guidelines

FOR USING THE TOOL



The Sainsbury Centre
for Mental Health

Overview

This tool aims to help services audit the cultural sensitivity of practice settings, with particular emphasis on the experiences and viewpoints of the people using and working in services. It will provide an opportunity for service users and staff to air their views and give feedback to the organisation. It will enable auditors to highlight areas for improvement and areas of good practice.

On its own, the tool will not prescribe changes, alter practice or challenge attitudes. Neither does it identify poor performance, or lack of culturally sensitive skills or knowledge base. It can, and we hope will, be used as a tool to influence services to enhance care. For this to happen, the 'audit loop' needs to take place, and should include planning for change, implementation, further audit and review. And this audit loop has to be part of a wider strategy for change, and a willingness to change, within the organisation.

The tool does not address issues for carers and families. Further work needs to be done to develop a tool that can incorporate carers and families, whose importance is often particularly strong within minority ethnic groups.

Setting the Scene

Why have a cultural sensitivity audit tool?

“No injustice is greater than the inequalities in health which scar our nation.”

The NHS Plan (DoH, 2000)

The NHS was conceived with the fundamental principle of equality of service provision for all. However it has been acknowledged that there are major variations in the service delivery and treatment (health outcomes) for some groups. Delivering effective services to meet the mental health needs and concerns of minority ethnic communities in Britain has long been recognised as problematic. For example, suicide rates are higher for Asian women and young black men, and schizophrenia diagnosis rates are higher for African and Caribbean men (especially second generation) (Cochrane & Sashidharan, 1996; Mental Health Foundation, 1997). Undoubtedly, there are inequalities in health service provision (Bhui & Olajide, 1999).

Black and minority ethnic groups are more likely to live in London and other large cities. Towns and cities, particularly in the south east of England, have recently seen an influx of refugees fleeing political unrest abroad. These groups, whether black British or newly arrived asylum seekers, may have specific (but very different) mental health needs. Service providers need to ensure that care is equitable and culturally sensitive or risk having services that are at best inappropriate and at worst discriminatory.

Progress with policy

“The government recognises that the social causes of ill health and the inequalities which stem from them must be acknowledged and acted on.”

A First Class Service (DoH, 1998a)

A number of key health policy documents highlight issues relating to minority ethnic groups, such as fair access to services (DoH, 1998a). *The NHS Plan* (DoH, 2000) notes that people in minority ethnic communities are less likely to receive the health services they need. *The National Service Framework (NSF) for Mental Health* (DoH, 1999) emphasises existing services' insensitivity to people of African and Caribbean ethnicity and notes that assessment procedures are inadequate for Asian communities. The NSF also stresses that minority ethnic groups (including refugees) suffer from social exclusion that compounds their mental health problems.

Clinical governance

“The means by which organisations ensure the provision of quality clinical care by making individuals accountable for setting, maintaining and monitoring performance standards.” (NHSE, 1998)

Clinical governance places the responsibility for fair access to effective and high quality care on health care providers, individuals and organisations (mainly NHS trusts). Lifelong learning, self-regulation and continuing professional development should contribute to better quality care. All staff must meet professional levels of competence and provide suitable care to black and minority ethnic service users. Chief executives, medical and nursing directors must ensure they offer effective multi-cultural services. One mechanism to assess the quality of care is clinical audit.

How can a cultural sensitivity audit tool help?

Measuring cultural sensitivity is important for meeting national requirements and providing excellent services.

An audit tool can provide performance indicators to show evidence that, for example, people from minority ethnic groups have been properly assessed and cared for, and that assessment and care are improving. It can be used to elicit users' views, which is an early priority of the National Survey of Users (part of the performance framework advocated by the government. DoH, 1999).

The Sainsbury Centre for Mental Health developed an audit tool as part of an evaluation of the cultural sensitivity of inpatient and community services in Hounslow, West London. It was subsequently used in a second evaluation in Hackney, then refined further. The refined version was piloted independently by workers in Middlesbrough who provided feedback, following which final changes were made. Since it can be refined, the tool is sufficiently flexible to be used in different areas and with different minority ethnic communities.

This document gives advice on how to use the audit tool. Examples are given from the evaluation carried out in Hackney, in London (Booklet Two). These show the kind of information the tool can provide and also how it can be used to encourage changes in practice and organisation.

What is an audit?

Audit can be considered as a process by which a 'learning organisation':

- monitors its own activities and
- implements a strategy to modify practice.

This assumes that:

- internal audit is acceptable to all stakeholders and
- the organisation is able to reflect critically on existing practice, recognise its shortfalls and support changes.

The advantage of internal audit is that the organisation itself implements and takes responsibility for individual clinical and organisational performance.

However, there may be a lack of expertise in conducting an effective culturally sensitive audit. It could be argued that self-audit is less objective and is at risk of excluding diverse stakeholders. Minority ethnic communities, users, voluntary organisations, primary and secondary care may all have important perspectives to contribute. It is worth considering setting up an audit team comprising members from both within and without the organisation.

Whatever approach is adopted, it is imperative that the audit cycle be completed in order to gain meaningful results.

Where organisations are generally performing well but have a few areas of poor practice, a separate strategy, with a timetable for improvement, needs to be drawn up for each area.

Structure of tool

The audit tool consists of three parts:

- information about the organisation conducting the audit and its local context;
- service user interviews;
- staff interviews.

The Organisational and Local Context

a) The local context: who constitutes your population?

A review of the local population needs to be carried out as part of the audit. This can be quite basic, but should include:

- ethnic breakdown of general population;
- community languages spoken;
- religious diversity;
- housing types (including homelessness);
- unemployment;
- vulnerable groups.

Most of this information can be easily collected from local government offices or libraries.

b) The local context: what constitutes your service?

Getting local data is a first step towards meeting government requirements for ethnic monitoring and ensuring that your services are appropriate for local people. For example, if there are refugees in your locality, translation facilities may be required. There may also be particular religious or other cultural needs and expectations to be met, as well as mental health problems specific to the traumas of being uprooted and encountering prejudice or danger.

Another important move is looking at the ethnic breakdown of staff throughout the organisation, with the aim of creating a workforce that is representative of the population it serves.

The sorts of data you need to gather are:

- ethnic, linguistic, religious, age and gender breakdown of users;
- ethnic, linguistic, religious, age and gender profile of staff, including a breakdown of grades and seniority of different ethnic groups and representation of ethnic groups on (executive and non-executive) committees and boards within the organisation. A comparison of the proportion of minority ethnic groups employed, compared with the proportion in the local population is also recommended. It has been found that staff from minority ethnic groups are over-represented in lower grades and under-represented in higher grades (Agnew, 2000; Alexander, 1999).
- your organisation's policies on racial equality, ethnically equitable services, etc. and results of any audits of the policies (including breaches of, and numbers trained in, policies);
- interpreting services and their range of languages (the training received by interpreters and by health staff in how to work with interpreters in mental health settings should also be available for scrutiny);
- data from any previous audits or evaluations on cultural sensitivity.

Other issues to look at include whether there are multi-faith places of worship. Spiritual aspects of care are rarely considered routinely. But insufficient attention to, for example, some religious groups' daily routines and requirements may compound the isolation and stigma of mentally disordered service users.

Are there single sex units? Single sex areas offer more safety and comfort to women who may be distressed on a mixed acute psychiatric ward. (Mixed wards should be phased out as a matter of national policy, but it is worth noting that some ethnic minority or religious groups require separate areas for men and women.)

Are there crèche facilities? Black and minority ethnic groups are predominantly young and a significant number have children.

c) The local context: voluntary and independent specialist service providers

Independent providers often bridge the gap between statutory services and public needs and expectations. Statutory services should acquaint themselves with any local groups for black or other minority ethnic groups, and work together to identify gaps in services, duplication and ways of working in partnership to provide appropriate services.

Guidance Notes – User Interview Schedule

This section provides:

- explanations for the sections in the user interview schedule and for some of the questions;
- practical guidance on interviewing;
- advice on interpreting answers to the questions.

General guidance

- Tick only one answer per question unless otherwise stated.
- Ask questions as they are specified in the tool.
- If you need clarification, ask additional questions.
- Users must be assured of confidentiality and that they will not be identified in any report.
- Users must also be assured that what they say will not adversely affect their care, and that the findings are intended to provide information for improving care in general.

Categorising ethnic groups

We recommend the use of the 2001 census ethnicity categories (self-selected by the user), complemented by place of birth, religion, whether English is a second language and any regional affiliations in terms of identity as perceived by the individual themselves.

Local variations (eg. a substantial Cypriot community) may require additional or supplementary categories. It is expected, and indeed hoped, that the tool will be adapted in this way. However it is not advisable to make adaptations to the rest of the audit tool which has been tested and piloted in its current form only.

BOX 1: Definitions of ethnic group showing their dynamic nature

“...a social group characterised by distinctive social and cultural tradition, maintained within the group from generation to generation, a common history and origin, and a sense of identification within the group. Members of the group have distinctive features in their way of life, shared experiences, and often a common genetic heritage” (Last, 1995).

“Ethnicity has been used as a dummy variable, as a crude proxy for complex combinations of social and economic and cultural circumstances” (Benzeval et al., 1995).

“What is central to ethnicity construction is not some objective criterion of cultural distinctiveness from another. Ethnicity is a process whereby one group constructs its distinctiveness from another. Processes of boundary construction vary over time and are subject to economic, political and social pressures; bonds of ethnicity may shift in meaning, be strengthened, weakened, or dissolved and they will have varied salience at different points in an individual's and group's biography” (Brah, 1996).

Part I: Gender, age and ethnicity

Each of these questions contributes to a picture of the service user's sense of identity and belonging, with the aim of helping the service improve existing services.

Q1–12: time spent in the UK helps assess the degree to which an individual might be familiar with local health services. Establishing whether English is a second language, whether the service user considers themselves to be a refugee or asylum seeker; their capacity to read English material and whether they need an interpreter or not, is important in determining where people might need extra or different assistance.

Religious (if any) affiliations may affect attitudes to treatment and the environment in which care is delivered and will need to be considered.

Dietary requirements may be influenced by culture and religious beliefs. For example, ignoring inpatients' dietary requirements may cause distress and so hinder treatment and recovery.

Part II: Accessibility

These questions establish how the user found out about the mental health service and look at who gave them help before they came to it. The aim is to establish the route into care, how easy it was to get help, what information was given and which service a user is (or was) using.

Some users feel that they didn't (and don't) need help and/or they didn't receive help from mental health services. We have therefore used the term 'contact' rather than 'help' for most questions.

Q13–16: the aim is to identify how minority ethnic groups gain access to mental health services and to highlight problems. Traditional routes into a service may be inappropriate for some minority ethnic groups, inaccessible to some or more likely for others. It may be, for example, that the police are disproportionately involved in some ethnic groups' admissions to hospital and this will need to be noted.

These questions are asking about the person's first ever contact with services. If this was some time ago, they may not remember. In this case, ask the person to talk about the last time they remember accessing the service, and check that you record which occasion the person is referring to.

Q17–19: services may not provide clear, understandable (spoken or written) information. Communication problems are likely to be increased by language or cultural misunderstandings.

Q20–21: these questions look at whether primary care is a route into services and whether local family doctors know about culturally appropriate services.

Part III: Language and interpreters

Communication in a foreign language about one's mental health is hard. This section aims to establish how much help was given with that communication and how useful the help was. This should help service providers look at questions such as whether interpreters or bilingual workers are more useful. However, users of the tool need to be sensitive. If it is clear early on that the person is fluent in English, it may be perceived as insulting or patronising for the respondent to be asked about the use of an interpreter.

Q22–28: these questions are for service users whose English is not fluent. You should seek to determine what help they had and what help they would prefer.

Q27: users are often not asked if they are happy for a relative to interpret, even though they may not wish to disclose their problems in front of relatives. In some cases, family problems might be at the root of difficulties. Family members may selectively report or interpret information, giving an impression of more or less distress, or indeed an inadequate assessment. The use of children is unacceptable and has been criticised for placing the burden of responsibility on the child and undermining the dignity and privacy of the adult.

Q29–30: clarity of communication is examined here. (Service providers may, for example, want to look at training staff in the use of plain English and avoidance of jargon.)

Part IV: General service use issues

This section explores the service user's experience of a service and what medication, counselling or other treatments have been prescribed or offered. The service user's impression of whether the service is improving or deteriorating is also sought. The degree of family involvement in decision-making (which is often not enough) is brought up. The section also asks about treatment that is desired by the service user but is not available.

Q31–33: information about medication (and what was explained about it) is sought here.

Q34–36: information about talking (and other) therapies offered is sought here. There is evidence that minority ethnic groups are less likely to receive talking therapies than white service users.

Q37–38: it is invaluable to gain a user's perspective on how a service is evolving and if it suits them. Space to comment on any specific issues a user may raise here is available as part of Q70–71.

Part V: The availability of appropriate staff

This section seeks information about whether a minority ethnic user was given a (gender and ethnic) choice of worker and if their preferred choice was actually available.

Q42–47: gender and ethnic or cultural 'matching' is one way of gaining trust and putting a user at ease. Users may request a worker with a specific cultural background and such requests need to be considered.

Part VI: Services specifically for the user's own ethnic group

This section looks at whether the user knows of services designed specifically with black and minority ethnic groups in mind and, if they have used them, how satisfied they were. Some aspects (e.g. personal care products) may seem unimportant but could be of particular value to the user. The provision of ethnically appropriate food can be particularly problematic. Catering within mental health settings has often been criticised as being of poor quality, regardless of cultural concerns. But minority ethnic communities may have the added problem of having to deal with food which does not match their normal diets or menus. This may increase their sense of isolation and accentuate the experience of being in an alien environment.

Part VII: User's views on the cultural appropriateness of mental health services

These questions seek the service user's views on how well the service has addressed their cultural and gender needs and on whether they have experienced racism. Practices and procedures are explored.

Q61–62: it is important to be as open as possible to these questions and be prepared to deal with very difficult situations. Support for the interviewer – for example, debriefing and a knowledge of who to report allegations to – must be available.

Q64–66: spiritual well-being is important for many people and a lack of appropriate facilities (e.g. for prayer) can be distressing.

Q70–71: the final questions allow the user to raise any other issues. This is an important opportunity and should not be rushed. Comments should be recorded as they are spoken, to preserve the service user's particular concerns.

Guidance Notes – Staff Interview Schedule

- Tick only one answer per question unless otherwise stated.
- Ask questions as they are specified in the tool.
- If you need clarification, ask additional questions.
- Staff must be assured of confidentiality and that they will not be identified in any report. Auditors must be careful to stick to this: some staff may be easily recognised in reports especially if from minority groups that are under-represented in the workforce.
- Staff must be assured that findings will be confidential and will be used to improve practice, not to identify scapegoats.

Part I: Gender, age and ethnicity

These questions establish the age, gender, ethnic and cultural profile of the workforce. As already noted, ethnic and cultural identity is complex. These questions elicit information about language, religion, ethnicity (using the 2001 census categories, see p6), experience, profession, and familiarity with the service to try and create an understanding of the make-up of the staff, and the degree of professionalism and expertise in any one service. (The organisation can also compare this information with the user interviews and identify any differences between the workforce's cultural origins and that of the service users.)

Q5: these religious categories can be complemented with questions about prayer frequency and the availability of a place of worship.

Q6–7: users and members of staff may be communicating in their second or third language and assessments are more complicated if carried out in a second language. Answers will suggest to what extent staff linguistic diversity reflects that of the local population and whether there is a need for interpreters.

Q8: a mix of practitioner specialities is important, as different professionals have different skills, perspectives and influences on mental health care.

Q9: the proportion of qualified staff to staff in training is important and requires monitoring. (Some evidence suggests that staff in training grades, rather than qualified staff, are disproportionately responsible for the needs of minority ethnic groups. This is not acceptable).

Part II: Communication

This section deals with the skills of the workforce in working with a multi-lingual population. Satisfaction with and frequency of use of interpreters are established, as is the availability of written materials in a variety of languages.

Communication and perception are crucial in mental health services. Yet, the user's and the professional's satisfaction with a consultation in which an interpreter is used are rarely considered as a measure of quality; this constitutes a major oversight in service planning.

Q13–16: the language skills of any member of staff who is asked to interpret should be tested. If their skills are poor, they should not be interpreting except in rare emergencies. (Employing organisations should consider language training for relevant staff.)

Part III: The availability of staff

This section asks about ethnic, gender and cultural matching, including whether it is viable in everyday work. This issue could be important, for example, when working with communities in which women do not openly discuss emotional and confidential problems with men, or where contact with men is taboo, or where their experience of men has been traumatic and has a direct bearing on the origins of distress.

The issue of user choice is controversial. Where staff views differ from those of clients, these conflicts may be particularly difficult. Yet, even where there is a choice in theory, it may not translate into practice if the gender and ethnic profile of keyworkers do not match users in range and quantity.

Part IV: Knowledge and views of cultural and ethnic issues

This section assesses staff awareness of anti-discriminatory policies and compares policy with actual provision. Staff knowledge of local communities and services to meet the needs of black and minority ethnic groups is assessed.

Q32: staff knowledge of organisational policies can be key to understanding where improvements can be made in meeting the needs of service users from minority ethnic groups.

Q33: over- or under-representation of particular groups within the workforce should be examined. On the other hand, this question (and Q40–43) may uncover staff misconceptions which could be dispelled through training or better management information.

Q38: this open question offers staff a chance to help identify problems and possible solutions.

Part V: Training regarding cultural issues

Training is an important way of improving practice. This section explores staff knowledge, training experiences and training needs, and employees' own assessment of their knowledge base and competency in meeting the needs of black and ethnic minority groups.

Q48–56: deficiencies in staff training should be fed into personal development plans for each member of staff, and taken on as a corporate issue to be tackled.

Part VI: The cultural appropriateness of the treatment environment

This section assesses staff views of the standards of their service regarding food, single-sex areas, personal care products, crèche facilities and the general cultural quality of the service.

Q67: staff have a chance to point out deficiencies and good points, and to offer ideas for service improvement. Their comments should be taken down verbatim.

After the Audit

Data collection and analysis

You will have four sets of data:

- data from the organisation which describes the organisation (for example, ethnic breakdown of staff; the existence of crèche and other facilities);
- data from the user interviews;
- data from the staff interviews;
- data from the council, library or other sources which describes the local population and local services.

For an audit, the point is to inform in order to change practice, to do so succinctly and in a timely way and to tailor the findings to the different stakeholder audiences. Analysis of the audit data needs to take these aims into account.

The data from the interviews with staff and users falls into two different types: quantitative and qualitative.

a) quantitative data

Quantitative data provides a numeric description ('facts and figures'), such as the number of users from different minority ethnic groups, the number who have used an interpreter, and the number of staff who have received training in working with minority ethnic groups. Usually quantitative data relates to fixed responses. These may be categories (such as: yes/no, male/female) or ratings (such as: not at all helpful, slightly helpful, very helpful).

The following table gives examples of the quantitative data and how it may be used.

Tool	Example of quantitative data from the audit	Use of the data
User tool	Number of service users from the various minority ethnic groups in the sample	Services can use information about size and ethnic breakdown of minority groups using the service to inform, for example, the need for recruitment of staff from certain ethnic groups, where training needs to be focused, etc.
User tool	Number of users in different age groups in the sample	Indicate which age groups are accessing the service. Tailor service developments, for example, for older people from minority ethnic groups. If the sample is limited in size, a description of the age groups interviewed might demonstrate the need for further interviews with people from different age groups to ensure adequate representation.
Staff tool	Number of areas providing single sex facilities	Help to identify areas of good practice.
Staff tool	Number of times staff were asked and could provide a keyworker of the same gender	Help to identify the demand for same-sex keyworkers and ability, or otherwise, to meet the demand.

Quantitative data is best presented in tables and/or graphs: a lot of numbers can be difficult for readers to assimilate.

b) qualitative data

Qualitative data provides information that is more subjective. It often deals with meaning (asking 'why' questions) and experience (through asking 'what' or 'how' questions). It does not deal in prescribed or fixed responses; rather the interviewee can respond in their own words to the question.

The qualitative information can be handled by simply asking individual clinical teams or the audit team to pick out the powerful and recurring themes. The advantage of using clinical staff is that the findings will be clinically relevant and it can also serve to raise staff awareness. Another approach may be for the audit team to undertake a thematic analysis and then test this out in feedback sessions with users and staff in order to refine the analysis. A more rigorous content analysis can be done but this does demand time and expertise.

Tool	Example of qualitative data from the audit	Use of the data
User tool	Users' experiences of their first contact with mental health services	Identify problem areas for targeting service developments, for example, identifying whether certain ethnic groups have preferred or more usual ways of accessing services or experiences which may prevent them accessing services in the future.
User tool	Users' experiences of their treatment as a person belonging to a minority	Identify areas for improving health care to minority ethnic groups, particularly in relation to staff attitudes and training needs.
Staff tool	Examples of culturally-specific food and personal products staff make available to users	Identify areas of good practice.
Staff tool	Opinions on how services could be made more attractive to people from minority ethnic groups	To help identify solutions to some of the problems around improving access for minority ethnic groups to mental health services. Also demonstrate valuing of staff opinions.

c) linking quantitative data and qualitative data

Qualitative and quantitative data can be used separately or, as is the case with this audit tool, together to enhance the quality of each. For example, the findings of this audit will provide quantitative information which indicates user satisfaction with using family members as interpreters (for example, how many users were satisfied and how many had mixed feelings). It will also provide qualitative information on why the users felt as they did. So we know not only how many users were happy or not, but also what they were unhappy about. This is crucial to the audit process because it offers information about where changes can be made.

Tool	Example of combining qualitative and quantitative data from the audit	Use of the data
User tool	Number of people whose carers were used as interpreters, how users feel about this and how this affects their communication	Provide evidence for how to improve interpreter services, including whether carer-interpreters are effective.
Staff tool	Staff training experiences: how satisfying and useful they found it and what it consisted of	Identify shortfalls in training, quality and appropriateness and areas where further training is needed across the staff groups.

Closing the audit loop

Presenting the results is not enough. Ideally, managers must set priorities for improvement on the basis of the most serious findings of the audit. Individual services should have a strategy and timetable for change. Services must then be re-audited and the new findings reviewed. We recommend a re-audit within two years to give services an opportunity to change, whilst maintaining momentum.

Each area needing attention should be examined via individual performance, team and service reviews. Training and supervision time must be a priority.

Clinical teams should consider collaborating with independent providers to develop their expertise, plug service gaps and improve individual care plans as well as general procedures.

Strategic elements

Table 3 in Booklet Two provides an example of an action plan proforma for a service to develop its organisational strategy for meeting the shortfalls identified using the audit tool.

Example Action Plan Table					
No.	Recommendations	Trust response	Action by	Date of action	Date when action will be reviewed
1.	Provide a training programme for all ward staff regarding anti-discrimination, improving cultural awareness and the use of interpreters.				
2.	The hospital wards should further develop existing links and build up new links with black voluntary organisations.				
3.	Each ward should have a designated member of staff whose role is to improve and co-ordinate services for users from minority ethnic groups. This staff member should have protected time to carry out these service developments.				
4.	Run hospital wide groups for minority ethnic groups.				

(Sathyamoorthy *et al.*, 2000) See Booklet Two for further examples.

The following elements should be looked at when developing a strategic approach to problems identified by an audit:

- human resources strategy, including promoting best practice in recruiting and retaining staff from minority ethnic groups across the range of disciplines;
- anti-discriminatory policy and monitoring;
- partnerships with voluntary and independent providers;
- interpreting and good practice guidelines to address linguistic diversity;
- staff training needs;
- shortfalls in organisational procedures and practice;
- user-staff matching;
- user views of the cultural and religious aspects of service;
- a user-staff-voluntary sector forum (feeding directly into the Trust board);
- advocacy service for people from minority ethnic groups.

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